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RECOMMENDATIONS

Reducing the Use of Emergency Departments and Reducing Preventable Admissions to the Hospital from Emergency Departments

Last session the Legislature required the Governor's Office of Health Policy and Finance (GOHPF), after seeking input from interested parties, to report to the Joint Standing Committee on Health and Human Services and the Joint Standing Committee on Appropriations and Financial Affairs regarding progress in reducing the use of emergency departments in hospitals and reducing preventable admissions to hospitals.

The Governor's Office of Health Policy and Finance convened a workgroup representing key interested parties and worked with the University of Southern Maine's Muskie School to secure funding from the Maine Health Access Foundation to address the concerns raised by the Legislature. The workgroup concluded that additional information was required to form a foundation for any recommendations to the Legislature. The workgroup expanded the scope of its deliberations by coordinating the Muskie School study with the MaineCare program.

The Muskie School completed an initial study and, based on guidance from the workgroup, delved more deeply into issues that study raised in the report attached. In addition, the workgroup analyzed studies and makes the following recommendations to GOHPF and the Legislature.

Introduction

The use of emergency departments for treatment of illnesses and conditions that can be appropriately managed in an office or clinic setting is a wide-spread phenomenon affecting all hospitals (in Maine and elsewhere). Our analyses indicate that the higher than average emergency department use experienced by some hospitals in Maine is predominantly a result of increased potentially preventable visits rather than a higher rate of use for emergency care and, therefore, should be amenable to interventions that would reduce ED use. The factors contributing to high use are complex, involve both health system arrangements as well as patient and provider behaviors that are frequently mutually reinforcing. Moreover, the incentives built into the health care reimbursement system reduce motivation to introduce changes that would bring down ED use.

The Governor's Office of Health Policy and Finance, with guidance from its Emergency Department Work Group, commissioned a comprehensive analysis of factors contributing to emergency department overuse and has thoroughly reviewed the data emerging from these analyses. Based on the evidence provided, there are a number of inter-dependent interventions that could reduce emergency department volume, shift care to appropriate treatment locations, and reduce unnecessary health care spending. The Work Group recommends the following strategies:

I. REALIGN REIMBURSEMENT INCENTIVES

Visits for diagnoses frequently seen and usually treatable in an office or clinic setting make up between one fifth and one quarter of all visits to the hospital emergency departments in Maine. Total preventable visits represent at least 30 percent of current ED traffic. Because emergency department visits for non-emergent conditions generate costs substantially higher than office or clinic visits for the same conditions, substantial savings can be realized by diverting these types of visits to appropriate care settings. Analyses of reimbursements of services based on claims data, comparing average costs of care for the same condition in ED settings vs. office settings are needed to estimate precise dollar savings. Modeling potential savings using real cost experience is recommended for the specific interventions discussed below.

A variety of interdependent strategies are available, without increasing current spending levels, to use incentives to encourage the provider community to assist in redirecting patients to appropriate primary care locations.

Strategy one: **Pay for Performance**. Adopt performance standards for all payers for hospital and physician organizations with established time deadlines and specified benchmarked rate reductions for certain ED visits identified by ICD-9 code. In accordance with current "pay for performance" agreements a tiered payment schedule would be adopted that decreased reimbursements to inefficient hospitals that fell below standards, and increased reimbursement to efficient hospitals that met or exceeded standards. Specific standards would be developed by the Dirigo Health Agency's Maine Quality Forum, working in consultation with MaineCare, the Maine Health Management Coalition and the ED workgroup.

Strategy two: **Capitation or Global Payment**. As an increasing number of hospitals and physician practices in Maine integrate vertically into comprehensive care entities, global payment strategies become feasible and potentially attractive for both payers and providers. A fixed annual payment per covered life to an integrated care system puts control of resource allocation in the hands of the health system and creates incentives for the most efficient care delivery. Savings would accrue to the health care system for shifting care from the ED to an office setting. Savings would accrue to payers, over time, with a net reduction in the number of ED visits.

II. ENCOURAGE THE EXPANSION OF ARRANGEMENTS FOR SAME DAY, UNSCHEDULED URGENT CARE VISITS.

Most of the providers interviewed for the commissioned study agreed that patients will default to the emergency department if they cannot be seen the same day that they contact a provider for a problem they deem to be urgent, will default to the emergency department. The analyses we reviewed indicated that the most critical health system factors that impact a community's rate of ED use are whether or not "walk-in" urgent care or open scheduling of same day appointments are available.

Strategy one: Open Access Scheduling. Many practices in Maine and elsewhere have switched to open access scheduling where patients are seen the same day they call for an appointment, whether it is an emergency, a routine physical or management of a chronic condition. This approach vastly reduces the problem of "no shows" for appointments and reports indicate that it increases both patient and provider satisfaction.

Strategy two: Extend Practice Hours. Many individuals in Maine, particularly low-income workers and MaineCare recipients, face significant hurdles in making and keeping health care appointments during regular working hours. These individuals may face lost income or loss of a job for taking time off during the day, may have limited transportation options, and may have difficulty arranging and paying for child care. Many pediatric practices across the state have, with great success, adopted some early evening and/or weekend office hours and early morning call hours for medical advice. Similar strategies for adult medicine could significantly expand access for patients who now use the emergency department non-emergent care needs. Hours can be "juggled" to include non-traditional times without necessarily increasing the net hours of patient care.

Strategy three: Expand provider familiarity and use of MaineCare member service patient outreach. MaineCare member services works with providers to reduce the incidence of missed appointments. Providers can telephone, fax, or mail in a request for member education, using a Member Education Request Form. MaineCare member services then contacts the patient in question, determines if specific barriers such as lack of transportation need resolution, provides information about office policy regarding cancellation of appointments and underscores the importance of keeping appointments.

III. IMPROVE THE AVAILABILITY OF MEDICAL ADVICE AND CONSULTATION IN EVENINGS AND ON WEEKENDS.

Providers participating in the MaineCare primary care case management (PCCM) program receive payment enhancements in exchange for a requirement to have arrangements 24 hours a day, 7 days a week, for patients to receive medical advice and to be referred to treatment, if necessary. In reality, based both on interviews with providers and focus groups with MaineCare enrollees, there are gaps in this coverage, particularly in rural areas.

A major gap is found in areas where all or most primary care is provided by federally qualified health centers (FQHCs). In other instances, health systems have contracted with out of state nurse call lines where screening and advice is provided without the benefit of a medical history or record, and where liability concerns would dictate that most callers be referred to an ED. Further, some focus group participants complained that they may wait up to several hours for a call back when they call for advice or assistance during non-office hours.

There are two strategies that should be explored to improve the availability and quality of 24/7 coverage.

Strategy one: Accept the role of the hospital as a 24/7 urgent care center in rural communities with small numbers of primary care providers. Establish a lower rate of reimbursement for urgent care that does not require the full resources of an ED. As many hospitals have done, facilities could establish a "fast-track" treatment center where patients are seen after triage. Or triage arrangements could be put in place before a patient enters the ED area and patients with complaints appropriate to an urgent care center could be directed to an on-site urgi-center rather than to the ED. A third approach that might be efficacious in some health service areas would be for a hospital to convert the ED to an urgent care center and not maintain a licensed ED.

A consultation with the Attorney General's Office may be required to determine the constraints of EMTALA in the development of these arrangements, including differential payment rates for non-emergent care.

Strategy two: **Explore with FQHCs the feasibility of their offering 24/7 coverage in communities where they are the major provider of primary care services**. Reimbursement for expanded coverage through FQHCs may be a more efficient means of providing after hours urgent care than through hospital EDs. An analysis of the costs of expanded care in the FQHC setting in relation to potential savings from reduced ED use would need to be conducted to determine the efficacy of this strategy.

Strategy three: Consider changes to the MaineCare PCCM program to improve the efficacy of primary care. A recent survey of primary care physicians and office managers who participate in the MaineCare program found that only 16 percent of respondents stated that the MaineCare Physician Incentive Program had a moderate or significant influence on their promotion of appropriate ED use. In addition, more than half of respondent office managers felt that MaineCare's current primary care case management fee is insufficient to cover the costs associated with managing their MaineCare patient load (Bowe et al., 2009). Hospital discharge data show that the rate of ED use by the MaineCare population is substantially higher than that of privately insured people in Maine. These facts, together with comments taken from MaineCare enrollees who participated in focus groups, indicate that some individuals in the MaineCare program are insufficiently linked to the primary health care system and use the emergency department as a substitute. Alternative models for the provision and financing of primary care that realign incentives, such as the medical

home model, should be considered for broad application to the MaineCare population as a substitute for the current PCCM program.

IV. IMPROVE PATIENT UNDERSTANDING OF THE IMPORTANCE OF A FUNCTIONAL PROVIDER/PATIENT RELATIONSHIP AND PREVENTIVE HEALTH.

The need for greater consumer understanding of the value of care management and a sustained partnership with a provider is particularly prominent in the MaineCare population. However, there is a sufficiently high volume of potentially preventable visits and sufficient numbers of frequent ED users among the privately insured to indicate that the need for patient education extends to individuals in all payer groups in Maine. A number of approaches could be taken to reducing the miscommunication that is evident between some ED users and their PCPs.

Strategy one: **Educational videos** should be developed for display in ED and provider office waiting rooms, providing information to patients distinguishing between the functions of an ED and a primary care provider and emphasizing the benefits to patients of an established and sustained partnership with a provider.

Strategy two: **A telephone intervention with ED users**. MaineCare initiated an educational intervention in 1999 specifically targeting MaineCare members with 2 or more ED visits for ear infections, upper respiratory infections and bronchitis. Nurses contacted the patients to educate them about alternatives to using the ED for these conditions. Although the proportion of members receiving the intervention was small (1%), an analysis of ED use by the Maine Health Information Center showed significant reductions in both overall ED use and ED use for targeted conditions by those receiving the intervention between 2002 and 2003, relative to those that had no intervention (Maine Health Information Center, 2004). This program was suspended for a number of years and has now been reinstated. Expanding this program to a larger population of ED users would be one possible strategy.

Strategy three: **Patient education by PCP practices**. An increased use of mid-level practitioners with a responsibility for working with patients on care plans and self-management of health care issues might be effective. Recognition and payment by payers of patient counseling and education might be cost effective if it reduced the number of preventable ED visits. This is another area of innovation where the experience of Maine's Patient Centered Medical Home Pilot Project may offer valuable lessons in practice organization and patient management which can be adopted more broadly across the state.

Note: All of the recommendations in I through IV above are aligned with current Maine demonstration projects, specifically, the Maine Patient Centered Medical Home Multi-Payer Pilot Program, the Maine Health Access Foundation's Integrated Care Initiative, and the Pay for Performance initiative of the Maine Health Management Coalition.

A logical starting point for testing the suggested reimbursement and care delivery

models would be through an expansion of these existing initiatives. Over time, payment models that worked satisfactorily for payers and providers in the context of the demonstration projects could be adopted more widely across the state.

V. SUPPORT AND EXPAND STRATEGIES TO REDUCE ED VISITS RELATED TO MENTAL AND BEHAVOIRAL HEALTH CONDITIONS THAT ARE READILY TREATED IN AMBULATORY SETTINGS.

Although not the most frequently identified issues found in the ED study, data shows that for youth and young adults 15 - 24, depression and anxiety were the fourth most common diagnoses for MaineCare enrollees and the 6th most frequent for uninsured individuals. Similarly, for adults aged 25 - 44, anxiety and depression were the fourth most frequent diagnostic categories among both MaineCare and uninsured ED users.

The Maine Health Access Foundation has supported 43 projects involving over 150 partnering organizations who work together to provide systems transformation support and integrated clinical services at over 50 sites across Maine. This work is also being advanced by the Department of Health and Human Services, and integration of physical and behavioral health is included as part of the current Patient Centered Medical Home Multi-payer pilot. New payment reform and system redesign models such as Accountable Care Organizations and Medicaid Managed Care should promote and incentivize integration to ensure that regulations, policies, and reimbursement are in place to support and pay for mental health needs that can be appropriately addressed within primary care.

VI. IMPLEMENT STRATEGIES TO REDUCE THE VOLUME OF ED VISITS RELATED TO DENTAL DISEASE.

Access barriers to dental care resulting in a high volume of emergency department visits arise both from financial barriers and provider shortages. Remedying the situation may require a multi-pronged approach.

Strategy one: Develop an initiative with the Maine Dental Association, dental surgeons, and other dental providers to create urgent care access for patients in settings other than EDs. Many ED providers express frustration over the mismatch between the resources of the ED and the needs of patients with dental pain or disease. Patients presenting with dental complaints can be assisted only with antibiotics and pain medication in the ED and must be referred to a dentist or dental surgeon for treatment of the underlying problem. Federal law, however, requires these patients (and all others who present for treatment at an ED) to have their health status evaluated before being released or referred to another provider. Thus, despite the need for referral to another care setting, each of these visits generates an ED visit charge as well as a charge from the dental service to which the patient is referred. Developing and expanding new models, such as the collaborative arrangement between Rumford Hospital and Community Dental where patients are referred in a collaborative arrangement from the ED setting to get timely ambulatory care, should be explored. Other options such as developing shared, on-call coverage arrangement among dentists, or an answering service that could direct calls to rotating on-call dentists could circumvent the need for these patients to present at an ED.

Strategy two: **Consideration should be given to defining how Maine can expand its available dental workforce capacity.** There are three models for new dental care providers currently being discussed and promoted nationally in the oral health community: dental therapists, community dental health coordinators and advanced dental hygiene practitioners (Pew Center on the States, 2009). Both Maine's dental association and association of dental hygienists have put forward proposals for licensure of new practitioners, but they are not in agreement as to type or level of independence. Moving this issue toward resolution and moving forward with implementation could have a substantial impact on Maine emergency department use.

VII. CONSIDER IMPLEMENTATION OF POLICIES TO IMPROVE MEDICATION MANAGEMENT IN EDS.

ED providers acknowledge that some ED patients have developed a dependency on prescription medications and generate visits to seek access to these medicines. While small in number, these individuals may be repeat visitors and may be some of those who present with dental pain. Another dynamic that can result in unnecessary visits are requests for prescription refills on weekends when patients can't reach their regular provider. ED providers are also handicapped in treating patients without access to their medical record and accurate information on current medications. Each of these issues can benefit from interventions.

Strategy one: Expand Use of Electronic Medical Records. The rapid and widespread deployment of electronic health records and the exchange of information through HealthInfoNet will assure that ED providers have maximum access to full medical histories in making medication decisions. Conversely, primary care providers will have access to treatment records for care received by their patients in EDs.

Strategy two: Expand Medication Assistance Initiatives. Between 2006 and 2009, the Maine Health Access Foundation funded 10 community-based provider organizations to develop new systems and mechanisms to increase access to free and low cost prescription drugs for uninsured and to improve medication management through in-home or telephone medication consultations to improve patient self-management and prescribing with targeted complex patients or post-hospital discharge. Six months into the program, over a third of participating patients reported improvements in health status, more than a third reported fewer medical care visits, and about one quarter reported fewer visits to emergency departments. In addition, many participants were able to access free medications through pharmaceutical donation programs or discounted drugs. Program design lessons should be widely disseminated to provider organizations and payers around the state to realize these same improvements in a larger population.

Strategy three: Making Use of the Maine Prescription Monitoring Program Database. The Maine Prescription Monitoring Program (PMP) collects information for prescriptions dispensed to Maine residents by commercial pharmacies and legally purchased from mail order and internet sources for US DEA Schedule II through Schedule IV drugs. Some Maine hospitals, in response to concerns about duplicative therapy and

about substance abuse and/or illegal use of prescription medications, are using the PMP to obtain records of prescription medications for individuals who seek care involving pain medication in the emergency department, or who request refills for prescriptions obtained from other providers. Some hospitals have instituted "no refill" policies in their EDs and some have paired the "no refill" policy with policies requiring clinical staff to use the PMP to see if patients are already using pain relievers or other controlled substances before prescribing. Uniform adoption of these policies across the state could reduce both inadvertent over-prescribing and inappropriate medication seeking behaviors.

Strategy four: Research best practice interventions with drug seekers. Health systems and payers in other parts of the country have experimented with interventions with ED drug seekers using mental health services in efforts to treat addictions and change behaviors. Such a program may be another example of a strategy where initial investment may generate savings greater than program costs, if successful interventions can be identified.

VIII. ALIGN PUBLIC POLICIES TO ENCOURAGE PRACTICES THAT REDUCE INAPPROPRIATE ED USE.

The State Health Plan for 2010 should address the recommendations in this report and include specific tasks to advance payment reform, the patient centered medical home, address workforce needs and include criteria to inform the certificate of need program, particularly for applications seeking to expand or renovate emergency departments